Waiver Billing: Elderly and Physically Disabled Waivers

Submitting Paper Claims

09/11/2013

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Introduction

- This Web-ex addresses Paper Claims for HCBS Elderly and Physically Disabled Waiver consumers <u>ONLY</u>

- Providers who enrolled after 7/1/13 were required to register for electronic fund payments (EFT) payments and electronic Remittance Advices (RA)

- Providers currently receiving paper checks and/or paper RAs must transition to EFT and electronic RAs

- New "Health Enterprise" payment software is targeting electronic claim submission

Montana's HCBS Waivers

- Home and Community-Based Services (HCBS)
- Montana has four waivers:
  o Developmentally Disabled
  o Elderly and Physically Disabled
  o Severe Disabling Mental Illness (SDMI)
  o Psychiatric Residential Treatment Facilities (PRTF)

    This web-ex specifically addresses billing for the   Elderly and Physically Disabled waivers.

Who's on First?

Community Services Bureau (CSB)
   Senior and Long Term Care Division (SLTC)
      Department of Public Health and Human Services (DPHHS)

CSB oversees and administers the Elderly and Physically Disabled waivers.

Case Management Teams (CMT) manage "slots" for each Consumer

Xerox contracts with DPHHS to process and pay Medicaid claims.

Case Management Teams

- Consumer must meet eligibility requirements
- Consumer works with CMT
- Limited amount of available funding
  - "Slots"
- CMT refers authorized services to Waiver Provider
  - Prior Authorization

Prior Authorization

- Consumer demographics and Medicaid ID #
- Provider name and Provider ID # (if known)
- Primary diagnosis/ ICD-9 CM diagnosis code
- Authorized Procedure Codes and Modifiers
- Dollar amount or number of units per service
- Date Span per service
- CMT contact name and phone #
- **<u>PRIOR AUTHORIZATION NUMBER!</u>**

Waiver Providers

o   Must be specifically enrolled as HCBS provider

o   Some Provider Types such as Durable Medical Equipment (DME) must enroll twice

o   Provider Type 28

o   "Atypical" versus "Typical"

- National Provider Identification (NPI)

is NOT required !!

Waiver Providers (cont.)

- All Waiver Providers have a "CHARGE FILE"
- CMT Approved List of Provider's billable:
  - Procedure Codes
  - Rates
  - Effective Dates of Service
- CSB manages data in MMIS software

Provider Responsibilities

- Know the regulations and requirements:

  - HCBS Manual, Section 600
  http://www.dphhs.mt.gov/sltc/services/communityservices/index.shtml

  - Administrative Rules of Montana (ARM)
  37.85.406 Billing, Reimbursement, Claims Processing and Payment
  http://www.mtrules.org/gateway/Department.asp?DeptNo=37

  - Montana Medicaid Provider Information
  http://medicaidprovider.hhs.mt.gov/

Provider Responsibilities (cont.)

- Monitor changes, upcoming events, and training opportunities

  o **Claim Jumper Newsletter**

  http://medicaidprovider.hhs.mt.gov/providerpages/disclaimercj.shtml

  -New issue on the first of the month
  -DPHHS and Xerox both post <u>all</u> important
       information in the Claim Jumper!!!

Provider Responsibilities (cont.)

- "Montana Medicaid Provider Information" site
  - "Resources by Provider Type"
    - "General Information for Providers" Manual
    - Fee schedules
    - ARM link
  - Announcements
  - Forms
  - Training schedule
  - Claim Jumper link
    http://medicaidprovider.hhs.mt.gov/

Provider Responsibilities (cont.)

- Report any changes in provider contact information, addresses, phone number, immediately to Xerox
  - Montana Medicaid Provider Home Page
    http://medicaidprovider.hhs.mt.gov/index.shtml
    - Forms/ Address Correction Form

Provider Responsibilities (cont.)

Verify consumer eligibility **each month** !!

o **Montana Access To Health**

(aka MATH or the Web Portal)

- Enroll online at:

https://mtaccesstohealth.acs-shc.com/mt/general/home.do

Waiver Billing Requirements

- Medicaid Waiver Consumer

- Waiver Provider

- Prior Authorization for requested service(s)

-Provider authorized to deliver the requested services

- Charge File

Waiver Eligibility

- Medicaid eligibility is **not** Waiver eligibility
- Office of Public Assistance (OPA) re-evaluates Consumer eligibility every month
- HIPAA and privacy
- If talking to OPA, the question to ask is:
  - **"Has WAIVER been ISSUED?"**

Waiver Eligibility (cont.)

- Check MATH for Waiver eligibility

Eligibility Spans		About HMK/HMKPlus			
Service Type Code	**Insurance Type Code**	**Payer Name**	**Plan Coverage Description**	**Eligibility Effective Date**	**Eligibility End Date**
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Full Coverage	05/01/2010	01/31/2013
Message Text: Elderly/Physically Disabled Waiver					

- May not be available at first of the month
- Tip: try using later eligibility date
    - Ex. 05/15/13 rather than 05/01/13

Waiver Eligibility (cont.)

- OPA challenges
- Most common reason claims deny
- **SAVE TIME! Confirm eligibility before Billing!**

Procedure Codes and Modifiers

- All Waiver Procedure Codes must be billed with a UA modifier

  o Exceptions: T2022 and T1016 Case Management

- If multiple modifiers are to be used, UA must be first

- Additional modifiers:

  o **TE**: indicates nurse supervision

    - As opposed to attendant services
    - Use together with UA : ex T1001 UA TE

Procedure Codes and Modifiers (cont.)

- **TS**: use when late timesheets are received for dates of service that have <u>already been paid</u>
  - Use Modifier instead of Adjusting claim
  - Use for these procedure codes ONLY:
  S0215, S5125, S5130, S9123, S9124, T1002, T1003,   T1005, and T1019

Clean Claims and Timely Filing

- ARM 37.85.406: "**Clean claim** means a claim that can be processed without additional information or documentation from or action by the provider of the service."

- ARM 37.85.406: "Date of submission to the Medicaid program is the date the claim is stamped "received" by the department or its designee" (i.e. Xerox)

- **Timely Filing**: Maximum of 12 months from the date of the service to submit a <u>clean claim</u>
  - All errors must be worked for the claim to be clean
  - 05/31/13 service date, clean claim by 05/30/14

CMS 1500 – Paper Claim

- Downloadable form NOT available
- Must be "regulation" size
- Process is very streamlined for our waiver
- Only the fields *specifically identified* are required for Elderly and Physically Disabled Waiver
- Additional fields may cause claim to deny

CMS 1500

Required Fields

- 1a – Insured's ID Number

o Medicaid ID as shown on Medicaid ID Card

Required Fields (cont.)

- 2- Patient's Name (Last Name, First Name, Middle Initial)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	

- o As shown on Medicaid ID Card

Required Fields (cont.)

- 10d. – "Reserved for Local Use

10d. RESERVED FOR LOCAL USE

G & SIGNING THIS FORM.

- - Approved ALTERNATIVE field for Medicaid ID
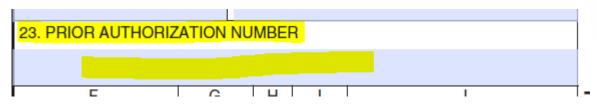 - o Use instead of 1a

Required Fields (cont.)

- 21 – Diagnosis or Nature of Illness or Injury
  (Relate Items 1, 2, 3, or 4 to Item 24E by Line)

- Decimal point on form lines up with code

Required Fields (cont.)

- 23 – Prior Authorization Number
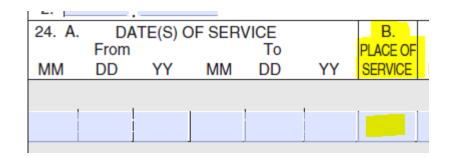

23. PRIOR AUTHORIZATION NUMBER

- - Must be included on claim
- - Must be the correct PA for the billed services

Required Fields (cont.)

- 24. A. – Dates of Service

- Two digit format: MM I DD I YY

Required Fields (cont.)

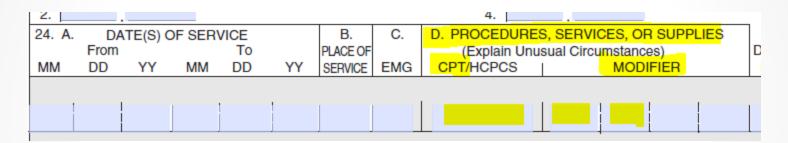- 24. B. – Place of Service

- Complete listing (beginning on page 20):

http://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html

- S0215 UA – Transportation-Miles can't use "12 – Home"

Required Fields (cont.)

- 24. D. – Procedures, Services, or Supplies

- "CPT" is the Procedure Code
- "UA" modifier ALWAYS REQUIRED
- "UA" before "TE" or "TS"

Required Fields (cont.)

- 24. E. – Diagnosis Pointer

- o Works in conjunction with 21
- o "1" primary diagnosis
- o Multiple: 1,2,3,4

Required Fields (cont.)

- 24. F. – Total Charges

- Dollars to the left of the dashed line
- Cents to the right of the dashed line

Required Fields (cont.)

- 24. G. – Days or Units

Required Fields (cont.)

- 28. – Total Charge

- Sum of column " 24. F.

Required Fields (cont.)

- 31. – Signature and Date

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED   DATE

NUCC Instruction Manual available at: www.

- Signature Date must be *after* the last date of service on the claim!

Required Fields (cont.)

- 33. Billing Provider Info & PH #
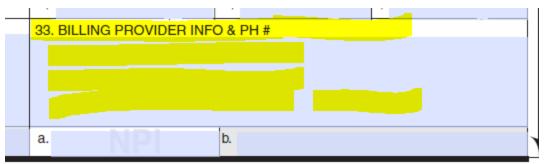

33. BILLING PROVIDER INFO & PH #

a. NPI   b.

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

- <u>Billing</u> Contact Phone #
- Zip + 4 for Zip Code

Required Fields (cont.)

- 33. a. – NPI: National Provider Identification

- LEAVE BLANK!

- A very few providers may already be successfully billing with an NPI. If this is your facility, please continue your current practice.

Required Fields (cont.)

- 33. b. – "G20" plus Atypical Provider Number

- Atypical Provider
  - Use 6 digits
  - Ex: G20123456

Remittance Advice

- Access electronically through MATH
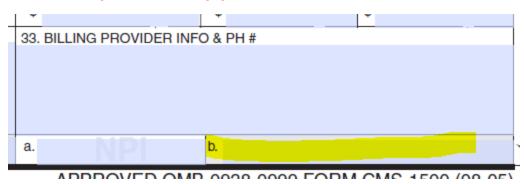- Reconcile claims and payments weekly
- Three sections: Paid, Denied, Pending
  - Paid claims can be Adjusted
  - Denied claims can be corrected and resubmitted
  - Pending claims must complete cycle
- Work the Reason and Remark codes
- 12 months from Service Date = "Clean Claim"

Common Reasons for Denials

- Claim submitted before eligibility in place
- Claim spans eligible and ineligible spans
- PA on claim is not correct for time span
- Invalid Diagnosis Code
- Missing Diagnosis Code Pointer
- Missing UA modifier
- Duplicate claim
- Overbilling the PA

Common Reason and Remark Codes

- 4 - Procedure code is inconsistent with the modifier or the modifier is missing
- 15 - The authorization number is missing, invalid, or does not apply to the billed services or provider
- 18 - Exact duplicate
- 29 – Time Limit for Filing has expired
- 31 – Patient cannot be identified as our insured
- 119 – Benefit Maximum for this time period has been reached
- 133 – Disposition of claim is pending further review

Individual Adjustment Request

- Form on "Montana Medicaid Provider Information" homepage/ Forms
- Box A – Complete in full
- Box B – <u>Only the data being changed</u>
  - In 8, "Please update PA # 12345678"
- Attach Remittance Advice
- Allow 4 weeks for processing

Individual

Adjustment Request

Individual Adjustment Request (cont.)

- A.3. Internal Control Number (ICN) from RA

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PAID CLAIMS - MISCELLANEOUS CLAIM

4082668                           05162013 05222013    2.000  T2031 UA    122.46    122.46
ICN 01322511815102000 PATIENT NUMBER-

                                  ***CLAIM TOTAL**************    122.46    122.46
```

- Individual transaction identification number
- 17 digits long

3. Internal Control Number (ICN)

Individual Adjustment Request (cont.)

- A. 4. NPI/API: **Atypical** Provider Number
- A. 5. Client ID Number: pull from original claim
  - ○ RAs only show Medicaid ID
  - ○ If SSN was originally submitted, use SSN

Individual Adjustment Request (cont.)

- Box B: Changes only

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			

Individual Adjustment Request (cont.)

- Ex. Changing only number of units

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	LINE 1	4	1

- Ex. Changing units and Billed Amount

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 1	4	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount	Line 1	40.00	10.00

Individual Adjustment Request (cont.)

- Box B. 8. Other/Remarks (Be specific)
  - Be descriptive but succinct
  - Technician does not see the original claim
  - Always include: "PLEASE UPDATE PA # xxxxxxxx"
- Corrected claim is not required
  - However, if there are many changes to claim a corrected claim may help with processing
- Attach Remittance Advice

Claim Credit

- "Claim Credit" to reverse a Paid Claim
- Use Individual Adjustment Request form
- **CLAIM CREDIT** in upper right hand corner
- Complete Box A
- Box B only needs "8. Other/ Remarks"
  - "Please **CLAIM CREDIT**"
  - "Please update PA # xxxxxxxx"
- After reversed, new claim(s) can be submitted

Upcoming Events

- Transition to EFTs and electronic RAs
- ICD 10 – Overhaul of diagnosis codes
    - 10/01/2014
- Health Enterprise
    - Spring 2015

Watch the CLAIM JUMPER !

Contacts

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